1.0 Description of the Services

1.1. Personal Care Services

Personal Care Services (PCS) covers the services of an aide in the recipient's private residence to assist with the recipient's personal care needs that are directly linked to a medical condition. The services must be authorized by the recipient's primary care physician, physician's assistant, or nurse practitioner working under the supervision of the physician (as set forth in the licensing regulations of the North Carolina Boards of Medicine and Nursing). PCS is a paraprofessional service and does not include skilled medical or skilled nursing care.

1.2. Personal Care Services-Plus (PCS-Plus)

Personal Care Services-Plus (PCS-Plus) is an enhancement to the PCS program. PCS-Plus is for recipients who have a qualifying medical condition and personal care needs that exceed the service limit for PCS. Services include assistance with personal care tasks such as bathing, toileting, ambulating, and monitoring vital signs. In addition, services such as housekeeping and home management tasks may be provided if they are essential to the personal care task(s) necessary for maintaining the recipient's health.

Refer to **Clinical Coverage Policy #3J**, **Personal Care Services-Plus**, for program-specific information.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. While there is no requirement that the service, product, or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

2.3 Recipients with Medicaid for Pregnant Women Coverage

PCS for recipients with Medicaid for Pregnant Women (MPW) is limited to medical conditions related to pregnancy or complications of pregnancy. Refer to **Section 3.3** for specific medical necessity criteria and to **Section 5.2.1** for service requirements.

2.4 Medicare Qualified Beneficiaries

Medicare Qualified Beneficiaries (MQB) are not eligible for PCS. Medicaid coverage is limited to coinsurance and deductible amounts from Medicare. Because PCS is not a Medicare covered service, MQB recipients are not eligible for Medicaid PCS.

3.0 When Services Are Covered

3.1 General Criteria

Medicaid covers PCS when:

1. The service is medically necessary.
2. The service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
3. The service can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
4. The service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider.

3.2 Medical Necessity

PCS aide services are covered only when the primary purpose of the visit is to provide personal care. Each of the personal care tasks provided must be directly related to the medical condition, must be medically necessary, and must be authorized on the PCS Physician Authorization for Certification of Treatment (PACT) Form **(Attachment F)** in accordance with program requirements. For the purpose of this policy and service, medical necessity means that if the plan of care is not implemented, the recipient's medical condition will deteriorate.

3.2.1 Activities of Daily Living

PCS covers aide services rendered in the private residence of a recipient who requires assistance with a minimum of two unmet activities of daily living (ADLs). The unmet ADLs must be identified on the PCS PACT form and must be addressed in the recipient's plan of care. (See **Attachment B** for a listing of ADL activities.)

1. An unmet need exists when the recipient cannot independently perform at least two personal care tasks because of a physical or cognitive impairment; and there is no household member, relative, caregiver or volunteer to meet the need on a regular basis or a third party payer is responsible for covering the service.
2. PCS must be the most cost-effective and appropriate form of care for the recipient. PCS is provided to assist, not replace, the help available from family members and community resources.

3.2.2 Medical Condition

The recipient must have a medical condition that requires the direct and ongoing care of his/her primary physician prescribing PCS and must be medically stable. "Medically stable" means that the recipient does not have a need, pertaining to the PCS plan of care, for continuous monitoring and evaluation by a licensed professional.

3.3 Coverage Criteria for Recipients with Medicaid for Pregnant Women Coverage

Medicaid covers PCS for recipients with MPW for:

1. Complications of pregnancy that confine the recipient to bed, which results in the recipient requiring assistance with personal care. The recipient must be confined to bed by the obstetrician. This may include pre-eclampsia with hypertension and edema and hyper-emesis gravidarium with dehydration. The patient must have premature labor pains that threaten miscarriage or premature birth or be pregnant with twins or multiples.
2. A pre-existing medical condition exacerbated by pregnancy, which results in the recipient requiring assistance with personal care tasks.

Note: All PCS for recipients with MPW coverage must be prior approved. Refer to **Section 5.2.1** for additional information.

3.4 Coverage Criteria for Infants and Children

PCS for infants and children must be assessed and authorized on an individual basis considering personal care tasks that are directly linked to the medical condition and not needs that are a parental responsibility and/or age appropriate. Refer to **Section 2.2** for further explanation of coverage under EPSDT.

3.5 PCS-Plus

To qualify for PCS-Plus, a client must be eligible for PCS and meet one of the following three criteria:

1. At a minimum, require extensive assistance with four or more ADLs. The identified needs must be met by the plan of care.
2. At a minimum, require extensive assistance in three or more ADLs and need the in-home aide to perform at least one task at the Nurse Aide II (NA II) level. The identified needs must be met by the plan of care.
3. At a minimum, require extensive assistance with three or more ADLs and have a medical or cognitive impairment that requires extended time to perform needed in-home aide tasks. The identified needs must be met by the plan of care.

Refer to **Clinical Coverage Policy #3J** for additional information on the PCS-Plus program.

4.0 When Services Are Not Covered

4.1 General Criteria

PCS is not covered when:

1. The recipient does not meet the eligibility requirements listed in **Section 2.0.**
2. The recipient does not meet the medical necessity criteria listed in **Section 3.0**.
3. The services are not provided in accordance with this policy and overall Medicaid requirements.
4. The procedure is experimental, investigational or part of a clinical trial.
5. The recipient's primary need is housekeeping and homemaking.

4.2 Hospice Benefit

A Medicaid recipient on Medicare or Medicaid hospice may not receive PCS.

1. Medicaid and Medicare hospice regulations require the hospice agency to provide the needed home health/homemaker services related to the terminal illness.
2. Hospice home health aides and homemakers can perform all of the tasks allowed under PCS, providing PCS is a duplication of available hospice care.

4.3 Duplication of Service

A recipient may not receive PCS and another substantially equivalent federal or state funded service on the same day. Examples of equivalent services include home health aide services and in-home aide services in the Community Alternatives Programs (CAP/AIDS In-Home Aide Services, CAP/Disabled Adults In-Home Aide Services, CAP/Children Personal Care Services, CAP-Mental Retardation/Developmental Disability [MR/DD] Personal Care Services and CAP-MR/DD Supported Living Services). This restriction also includes any other federal or state funded service that provides assistance with ADLs, Level II or Level III personal care in the home.

4.4 Recipients with Medicaid for Pregnant Women Coverage

Recipients with MPW coverage are not eligible to receive PCS for conditions that are not pregnancy-related. (Refer to **Section 5.2.1** for information on prior approval for recipients with MPW coverage.)

4.5 Infants and Children

PCS is not intended as a substitute for child care, day care or after school care. PCS is not covered for infants or children when the personal care needs do not meet the medical necessity criteria listed in **Section 3.0** or the needs are a parental responsibility or are not age appropriate.

4.6 Non-Covered Tasks

Tasks not covered under PCS include:

1. Care of non-service related pets and animals.
2. Yard/home maintenance work other than ensuring a safe pathway in and out of the recipient's residence.
3. Transportation: No medical transportation is provided as it is covered through DSS and is considered a duplication of services. No school transportation is provided as it is covered by the school system. Medicaid does not reimburse for aide time spent taking or accompanying the recipient to a physician's office, clinic or for any other type of medical appointment.
4. Assistance with homework.
5. Companion "sitting" or leisure/social activities provided outside a covered PCS task.
6. Continuous monitoring or ongoing client supervision.
7. Licensed practical nurse (LPN) services or registered nurse (RN) skilled nursing services.
8. Home management tasks cannot be completed for other residents of the household.

4.7 Non-Covered Service Locations

PCS is not covered when the recipient is receiving nursing facility services, adult care home (including group home) services, hospital inpatient services or PCS-type services at school.

5.0 Requirements for and Limitations on Coverage

5.1 Limitations on Service

Medicaid payment for Personal Care Services is limited to the aide services delineated in this policy, RN in-home initial assessments, in-home reassessments by the RN, annual reassessments, and RN supervisory visits.

1. Medicaid covers no more than 3.5 hours (14 units) of PCS per day and no more than 60 hours (240 units) of PCS per month, which includes the RN clinical supervisor assessment, reassessment, and supervisory visits.
2. Up to an additional 20 hours of PCS per month are available through the PCS-Plus program. Additional PCS hours/PCS-Plus hours may also be available under the provisions of EPSDT provided that medical necessity exists. Health care services will be provided in a frequency and amount consistent with the recipient's medical needs and in accordance with established program requirements.

   Refer to **Clinical Coverage Policy #3J** for additional information on the PCS-Plus program.

5.2 Prior Approval

5.2.1 MPW Recipients

Prior approval for PCS is required for recipients with MPW coverage. Prior approval for MPW is obtained using the Medicaid Request for Prior Approval Form 372-118. PCS requirements, guidelines, and limits remain the same for MPW recipients on PCS.

5.2.2 PCS-Plus

Prior approval is required for PCS-Plus. The PCS provider must submit a request for PCS-Plus to the Division of Medical Assistance (DMA) PCS-Plus Nurse Consultant. The PCS-Plus Nurse Consultant will review the requests on an individual basis.

Refer to **Clinical Coverage Policy #3J** for additional information on the PCS-Plus program.

5.3 Provision of Service

Services provided for a recipient prior to an inpatient admission, on the date of an admission, and services provided for a recipient returning home on the date of discharge can be billed to Medicaid.

5.4 Personal Care Tasks

Medicaid covers only the personal care tasks indicated on the recipient's plan of care from the list of covered tasks identified in **Attachment B** when they are provided by an in-home aide within the time allotted for the task.

5.4.1 Time Guidance

If the recommended time guidance (see **Attachment B**) does not allow adequate time to complete a personal care task for a recipient, the RN must document the need for a time exception on the PCS PACT Form or other supporting documents i.e., nurse's notes. All such documentation must be maintained in the recipient's record.

5.4.2 Other Medical Considerations

1. Physical conditions that may affect the amount of time allocated to a personal care task include, but are not limited to the following: dyspnea, shortness of breath with minimal exertion, continuous use of oxygen, medication assistance, incontinence needs, and endurance or pain issues.
2. Cognitive impairment, causing the recipient to require extensive hands-on assistance with a personal care task, may also affect the amount of time allocated to a personal care task. This is demonstrated by lack of alertness, orientation, or by the inability to shift attention and recall directions more than half of the time.

5.5 Delegated Medical Monitoring and Activities Language with the PCS PACT

Medicaid covers non-skilled medical tasks that are delegated to the in-home aide by the RN clinical supervisor, in accordance with all applicable North Carolina laws, practice acts, standards of care, and agency policy. The tasks include, but are not limited to: reminding and/or assisting recipient with pre-poured medications, assisting with finger capillary blood sugar (FCBS), monitoring vital signs (temperature, blood pressure, respirations and pulse), measurement of intake/output, and agency approved NA II tasks as identified by the North Carolina Board of Nursing. (See Nurse Aide II Task List published by the North Carolina Board of Nursing and 21 NCAC 36.0221-License Required and adopted by reference.)

5.6 Treatment

Medicaid covers:

1. range of motion exercises;
2. NA I approved tasks as per the N.C. Board of Nursing NA I Task List and 21 NCAC 36.0221-License Required (adopted by reference); and
3. NA II approved tasks as per the N.C. Board of Nursing NA II Task List and 21 NCAC 36.0221-License Required.

5.7 Home Management Tasks

Medicaid also covers the home management tasks indicated on the recipient's plan of care from the list of covered tasks identified in **Attachment B** when they are provided by an in-home aide within the time allotted for the task and the task is related but incidental to the recipient's personal care needs. Home management tasks are secondary to the personal care tasks and are provided only when necessary for maintaining the recipient's health and are directly related to his/her medical condition and identified personal care needs. The tasks are directly related to the primary needs. The tasks must be completed for the recipient only, not others living within the household.

The PCS in-home aide is expected, when possible, to complete multiple tasks simultaneously. For example, while the laundry is in the washer, the in-home aide could be preparing a meal or completing other home management tasks.

1. Linen change, mopping, laundry, etc. are not to be performed daily. Thus, the time allotted in the plan of care should reflect daily needs. Specific documentation is required to validate that needs have been identified and to support that tasks must be provided more frequently. For example, more frequent linen changes for an incontinent recipient.
2. Weekly home management time should never exceed weekly personal care time. Over the course of a week, personal care activities must be the primary activity during the visit.
3. In homes where more than one recipient is receiving Medicaid PCS, home management tasks should not be duplicated. For example, the common bathroom, bedroom, and living areas, etc. should not be cleaned twice per visit.

5.8 Nurse Aide II Tasks

In addition to the personal care tasks, Nurse Aide II tasks may be provided as part of PCS when the tasks are performed according to the N.C. Board of Nursing rules and regulations.

1. Completion of a NA II training and competency evaluation program and listing with the N.C. Board of Nursing Nurse Aide II Registry or special training of NA I personnel to perform up to four NA II tasks with N.C. Board of Nursing approval is required.
2. The PCS provider should contact the N.C. Board of Nursing for guidance if considering provision of any NA II tasks or if there are additional questions related to this.

6.0 Eligible Providers

6.1 Licensure Requirements

PCS must be provided by a Medicaid-enrolled PCS provider in North Carolina with a current license from the Division of Facility Services (DFS) to provide in-home aide services. Medicaid cannot reimburse individuals for providing PCS.

6.2 Conditions of Participation

The agency must submit an application to DMA and be approved as an enrolled PCS provider to receive payment from Medicaid. The agency is responsible for upholding the requirements of the Medicaid provider enrollment agreement.

1. Each licensed site must enroll for a separate and distinct Medicaid provider number. The provider must bill with a site-specific provider number.
2. Each licensed site must participate in the PCS Quality Assurance and Utilization Management program (see **Attachment C).**
3. The provider must complete and submit PCS cost reports in a timely manner.

6.3 Staffing Qualifications

6.3.1 RN Qualifications (Clinical Supervisor)

The individual conducting the PCS assessment and PCS supervisor must be an RN licensed by the N.C. Board of Nursing and have documentation demonstrating successful completion of the DMA-approved PCS certification training. The RN may be an employee of the PCS provider or be under contract with the PCS provider. No other individual may collect the data for the RN to use for evaluation, care planning or supervision, except as indicated in **Section 7.3.3** for brief interruptions in service.

6.3.2 PCS In-Home Aide Qualifications

In-home aides must meet the in-home aide qualifications stated in the N.C. Rules Governing the Licensure of Home Care Agencies (10A NCAC 13J.1110) and may not be the recipient's spouse, child, parent, sibling, grandparent or grandchild. This also includes any person with an equivalent step or in-law relationship to the recipient. The provider is responsible for assuring that the aide assigned to provide care is competent to carry out the assigned tasks.

7.0 Additional Requirements

7.1 Recipient Referral, Initial Assessment, and Authorization for Services

1. The PCS provider may obtain a referral from a variety of sources including a physician, recipient inquiry, family or a social service agency. Direct solicitation by the PCS provider agencies or agency representatives to recipients and/or their representatives for PCS services is prohibited.
2. The PCS provider must obtain a verbal or written order from the recipient's primary physician to conduct an initial assessment to determine whether the recipient qualifies for PCS. The verbal order for an assessment may be documented on a physician's supplemental order form and/or noted on the PCS PACT Form in field 47. The verbal or written order to assess for PCS must be signed by the recipient's primary physician within 60 days.
3. After the initial assessment and if the recipient meets PCS criteria, the provider must notify the primary care physician to obtain a verbal order to begin services if care is needed before the signed PACT form is received. The PCS provider must obtain the primary physician's signature on the PACT form within 60 days of the verbal or written order which authorized services to begin. The PCS provider must prepare the PCS PACT for the physician's authorization signature. A PCS provider must have an authorization (signed PCS PACT Form) from the recipient's primary physician for all PCS billed to Medicaid. An electronic signature may be used if the provider's process is consistent with federal regulations, N.C. Rules Governing the Licensure of Home Care Agencies, rules and regulations promulgated by the North Carolina Boards of Medicine and Nursing, and agency policy.

7.2 Physician Order for PCS (Initiation and Continuation)

The primary physician orders PCS in-home aide services. A nurse practitioner (NP) or physician assistant (PA) working under the supervision of the recipient's primary physician may also authorize PCS as set forth in the licensing regulations of the North Carolina Boards of Medicine and Nursing. For purposes of this policy, whenever the term primary physician is used, it also pertains to the NP or PA as referenced above.

1. Before PCS in-home aide services are started after the initial assessment or continued at the time of the annual reassessment, the PCS provider must obtain the primary physician's verbal or written order. Back dating is not allowed.
2. When the primary physician gives a verbal order to begin or continue PCS services, the provider may document that a verbal order was given either on the PCS PACT Form in field 47 or on a separate supplemental order form. If the provider documents the verbal order to initiate or continue PCS services on the PCS PACT Form, then an additional supplemental order form is not required. If the order is given verbally, the agency must obtain the physician's signature within 60 days of the verbal order date. An electronic signature may be used if the provider's process is consistent with federal regulations, the N.C. Rules Governing the Licensure of Home Care Agencies, rules and regulations promulgated by the North Carolina Boards of Medicine and Nursing, and agency policy.
3. If the physician's order to start or continue PCS services is a signed written order, it must be incorporated into the recipient's clinical record. This does not replace the signed physician certification on the PCS PACT Form, which must be signed by the physician within 60 days of the written order for assessment.

7.3 PCS Recipient Assessments and Reassessments

Only the RN representing the PCS provider and who has demonstrated program competency as outlined in this policy may conduct in-home, face-to-face PCS assessments. The initial assessment and annual reassessment for PCS must be conducted by the RN in the recipient's private residence. The RN must individually assess the need for PCS for each recipient. The need for PCS must be established by an assessment of the recipient's medically related personal care needs, home environment, and support system.

7.3.1 Initial Assessment

An initial assessment by an RN is required to collect information to determine if the recipient qualifies for PCS. The RN must document assessment findings on the PCS PACT Form, identify the unmet needs, and develop a plan of care to meet the identified needs.

7.3.2 Annual Reassessment

An annual reassessment is required for the recipient to continue with PCS. The annual reassessment must be completed and the physician order obtained to continue PCS services before the anniversary date of the initial assessment or last reassessment. The RN must document assessment findings on the PCS PACT Form following the same procedures for the initial assessment. Back dating is not allowed.

7.3.3 Reassessment When There is a Lapse in Service

If the PCS provider has not discharged the recipient, a reassessment is required following a lapse in PCS due to institutionalization or an unplanned lapse in PCS greater than seven service days or discharge of the recipient for any reason. The provider may resume PCS services following a lapse in services only after the RN has conducted a reassessment to determine that PCS remains appropriate for the recipient. The RN may conduct this reassessment in the recipient's private residence or by collecting information from a hospital or nursing facility discharge planner, primary physician, or other licensed health professionals providing care. The RN must document any changes on a new PCS PACT Form and update the plan of care following DMA and DFS requirements regarding plan of care revisions. If there are no updates to the assessment or plan of care, the RN must document this on a clinical note in the recipient's record. If either the supervisory visit or the annual reassessment was missed due to a lapse in PCS, as described above, then this follow-up assessment must be conducted in the recipient's private residence prior to resuming the services.

7.3.4 Reassessment for Changes in the Recipient's Condition

A reassessment is also indicated when there are significant changes (either improvement or decline) in the recipient's condition. The RN conducts this type of reassessment in the recipient's home and documents any significant changes in condition as defined in the provider's policies on a new PCS PACT Form. The RN must update the plan of care following DMA policy regarding plan of care revisions. If there are no updates to the assessment or plan of care, the RN documents this on a clinical note in the recipient's record.

Changes in the recipient's condition may be detected by the RN's review of the PCS In-Home Aide Service Logs, the implementation of the plan of care, the recipient's response to the plan of care, or telephonic communication with the recipient, caregiver or in-home aide.

Providers must develop policies to address these reassessments. Refer to **Attachment E** for an example of a reassessment policy.

7.3.5 Reassessments that Occur Between the Initial Assessment and the Annual Reassessment

At times, a reassessment may have occurred between the initial assessment and annual reassessment date. If this reassessment requires completing the PCS PACT Form and obtaining the primary physician's signature, then the date of this reassessment becomes the new anniversary date for the reassessment. As a result, the next reassessment must be conducted no more than 365 days from this new anniversary date.

7.4 Physician Authorization for Certification and Treatment (PACT) Form

7.4.1 PCS PACT Form

Providers must obtain the PCS PACT Form from the DMA website. It is mandatory that providers use this form. The form and additional instructions for completing the form are available on the DMA website at http://www.dhhs.state.nc.us/dma/forms.html.

Documentation on the PCS PACT Form at recipient assessment times as specified in this policy serves as the basis for determining whether the recipient qualifies or continues to qualify for PCS.

1. All PCS providers must use the PCS PACT Form for all Medicaid PCS recipients. All fields on the form must be completed as applicable.
2. The PCS PACT Form must be completed prior to the start of the service and at least annually, every 365 days, as long as the recipient receives PCS.
3. The RN uses the assessment to develop the plan of care on the PCS PACT Form.

The PACT Form documents all of the following:

1. The date, time, and duration of the assessment.
2. The type of assessment (initial or reassessment).
3. The recipient's age, sex, marital status, and place of residence.
4. The recipient's mental and physical health status, including the diagnoses and medical conditions related to the need for PCS with the prognosis; diet and nutritional needs; ADLs, activity restrictions; medications, treatments, and therapies.
5. The recipient's functioning in each ADL, the related need for assistance, and the expected duration of the need.
6. The recipient's ability to perform each covered personal care task, housekeeping and home management task, and the related need for assistance. The expected duration of the need is determined and documented.
7. The home environment as it relates to the recipient's personal care and whether the environment is adequate to safely carry out the plan of care; the age, sex, and relationship of other household members; equipment used in the home; and safety measures.
8. The absence of availability of resources on a regular basis from formal services, family, friends, and others, including details of the extent, timing, and expected duration of the assistance.

7.4.2 Certification

The RN assessor certifies by signature on the PCS PACT Form that he/she completed the in-home assessment, determined the need for PCS, and developed the plan of care. The certification includes an attestation regarding the accuracy of the assessment and the determination and notes: **Falsification: "An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Nursing for investigation."**

The physician certifies by signature on the PCS PACT Form that he/she is the primary physician and that the recipient is under his/her care and has a medical diagnosis with associated physical/mental limitations warranting the provision of PCS as stated on the plan of care included in the PCS PACT Form. **The primary physician shares responsibility with the RN assessor and if he/she certifies a material and false statement will be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Medicine.**

7.5 Signature

The RN must sign the PCS PACT Form to certify that the information is accurate and that he/she is the same RN who conducted the assessment and completed the form.

7.6 Accuracy of Assessment

The PCS provider is also responsible for the accuracy of the assessment.

7.7 Development of the PCS Plan of Care

PCS must be provided under a plan of care based on the RN's assessment and certified as needed by the primary physician. The RN and the PCS provider have a shared responsibility for the accuracy of the plan of care. The RN establishes the plan of care in collaboration with the recipient's primary physician, the recipient, and the recipient's formal/informal caregivers. The RN revises the plan of care as the recipient's needs change (either improves or deteriorates). The plan of care is located on the last page of the PCS PACT Form. In addition to the plan of care, the provider may develop a more detailed aide assignment from the plan of care. However, Medicaid payment for in-home aide services is limited to the tasks identified on the plan of care. The plan of care includes:

1. The days of the week the in-home aide is needed to provide care for the recipient, the tasks to be performed by the in-home aide on each day, and the estimated time needed each day to accomplish the tasks assigned for that day. No range of hours can be used on the plan of care.
2. The objectives and goals related to the provision of PCS.
3. Verbal order documentation and the primary physician's certification.
4. Expected discharge date from PCS.

The PCS provider should initiate care within 14 calendar days of the physician's authorization as documented on the PCS PACT Form and plan of care. If care is not initiated within 14 days of the authorization, the client must be reassessed. The tasks must be provided according to the plan of care and the provider must ensure that only in-home aides who are qualified to provide the needed care are assigned to the recipient.

7.8 Plan of Care Revisions

When the RN identifies an unmet need or a change in the recipient's condition, the plan of care must be revised. The PCS provider is responsible for communicating plan of care changes to the in-home aide.

The tasks and the time assigned for completing personal care tasks should be reviewed periodically by the RN. The time assigned to meet the recipient's needs must be consistent with the tasks identified to meet the needs. The RN must revise the plan of care as follows:

7.8.1 Significant Revisions in the Plan of Care

A significant change in the plan of care occurs when the RN has identified additions or deletions to personal care tasks based on an assessment that results in an increase or decrease by 60 minutes or more per week in the total weekly assigned time.

1. The RN documents significant changes in the plan of care by completing a new plan of care. Before the new plan of care is implemented, the provider must have either a verbal or written physician order to initiate the change or change PCS. The physicians order for the revision of the plan of care must be a signed written order within 60 days of the verbal order and it must be incorporated into the client's clinical record.
2. Physician certification is required for significant changes in the plan of care. When the physician gives a verbal order to add or delete personal care tasks and/or to change the total weekly assigned time, the provider may document in field 47 of the PCS PACT Form or on a supplemental order form that a verbal order was given. If the provider documents the verbal order on the PCS PACT Form, then an additional supplemental order form is not required. If the order is given verbally, the provider must obtain the physician's signature within 60 days of the verbal order date. If the physician's order for the revision to the plan of care is a signed written order, it must be incorporated into the recipient's clinical record. This does not replace the signed physician certification on the PCS PACT Form. An electronic signature may be used if the provider's process is consistent with federal regulations and as allowed by DFS, the North Carolina Boards of Medicine and Nursing, and agency policy.

7.8.2 Non-Significant Revisions in the Plan of Care

1. **Non-significant Permanent Revisions:** Non-significant permanent revisions to the plan of care may be made by the RN to address recipient preferences. Non-significant revisions to the plan of care only involve moving personal care tasks from one day to another without impacting the total weekly assigned time and changes to non-medical or incidental home management tasks without impacting the total weekly time more than 60 minutes a week. These revisions do not require a physician order.

   The RN documents non-significant permanent revisions to the plan of care and the tasks to be completed to meet the recipient's needs by completing a new plan of care or revising a copy of the current plan of care, signing, and dating the revisions. The provider should not alter an original plan of care. The plan of care, even with a permanent change, may not exceed PCS daily limits.

2. **Non-significant Temporary Revisions:** Examples of temporary revisions include when a recipient does not need PCS for a few days because he/she can receive the service from an informal resource; a temporary change in the recipient's home environment or support system; a medical appointment conflict on a scheduled PCS day; a request that a home management or personal care task be done on a different day; or when the service days during the week need to be changed due to inclement weather.

The RN documents non-significant temporary revisions to the plan of care and the tasks to be completed during the temporary change to meet the recipient's needs by completing a new plan of care or revising a copy of the current plan of care, signing, and dating the revisions. The provider should not alter an original plan of care. The plan of care, even with a temporary change, may not exceed PCS daily limits. Temporary revisions to the plan of care can only be made to address the recipient's missed service needs.

7.8.3 Plan of Care Revisions Due to PCS-Plus

When PCS-Plus is prior approved by DMA, the plan of care must be amended with the additional time and tasks that reflect the start of PCS-Plus services. The RN documents these revisions to the plan of care by completing a new plan of care or revising a copy of the current plan of care, signing and dating the revisions. The provider cannot alter an original plan of care. A physician order is not required for a change related to the start of PCS-Plus unless the change requires implementation of a pharmaceutical or medical regimen. A physician order is required for the implementation of a pharmaceutical or medical regimen.

7.9 Registered Nurse Supervision

The RN clinical supervisor representing the PCS provider must conduct a supervisory visit in the recipient's home with the recipient present within 90 days of the initial assessment visit and at least every 90 days thereafter. Supervision must be provided by an RN who has successfully completed the DMA-approved PCS certification training.

1. The RN clinical supervisor must document the supervision visit on a supervisory note that includes the required elements of supervision. (Supervisory notes are included in the recipient's clinical record.) The required elements of the supervisory note are:
   a. name of client,
   b. date of visit,
   c. RN time in and out of home,
   d. name and credentials of RN supervisor,
   e. type of visit,
   f. recipient evaluation,
   g. employee observation, noting recipient satisfaction,
   h. care plan review, and
   i. revision, if indicated, based on identified needs.
2. An on-site supervisory visit in the recipient's home with the in-home aide present must be conducted at least twice a year. The year is calculated based on the initial assessment date or the last annual reassessment date.
3. The RN clinical supervisor must complete the following during the supervisory visit:
   a. Document any change in the patient's medical condition and plans for responding to the change.
   b. Review the PCS aide's performance, examine the PCS In-Home Aide Service Logs to evaluate implementation of the plan of care, and respond to questions and concerns voiced by the aide and/or the recipient.
   c. Determine the recipient's level of satisfaction (perception) with the services provided.

d. Complete a nursing evaluation during the visit, including review of the:
   i. Recipient: medical condition, specific to primary diagnosis and diagnosis pertinent to ADL deficits qualifying for PCS, changes in recipient (including hospitalizations, other services, others who participate in home environment), and continued need for PCS.
   ii. Delivery of plan of care: tasks and time in the plan of care meet identified needs; plan is revised based on the evaluation. Recipient continues to need PCS. If hours change, additional needs and tasks to meet needs are identified on the plan/note.
   iii. Supervision of the in-home aide implementing the plan of care and interacting with the recipient.
   iv. Evaluation and consideration of the recipient/family's perception of care.

7.10 In-Home Aide Visits and Documentation

The purpose of each PCS in-home aide visit is to meet the recipient's personal care needs as identified on the PCS PACT Form and plan of care. If the PCS In-Home Aide Service Log does not reflect the plan of care, the reason for this discrepancy must be documented in the recipient's record. All PCS provided by the in-home aide must be documented on a PCS In-Home Aide Service Log.

7.10.1 PCS In-Home Aide Service Log

The PCS provider must maintain a PCS In-Home Aide Service Log for each aide providing PCS to a Medicaid recipient. The PCS In-Home Aide Service Log may be created by the PCS provider but must conform to the following requirements:

1. The log must document the date, time spent providing services, and tasks provided. At the end of each in-home aide visit, the aide must enter the date of the visit, the time work began, the time work ended, and the tasks performed.
2. The PCS In-Home Aide Service Logs should be developed in a weekly or daily format.
3. If different aides provide services to the recipient, each aide must maintain a separate log for the recipient.
4. The aide must sign and date the PCS In-Home Aide Service Log to certify the accuracy of the information recorded.
5. The recipient must sign and date the PCS In-Home Aide Service Log at least once per week to certify that the tasks were completed on the dates and times listed and that the tasks were performed satisfactorily. The provider must inform the recipient why the PCS In-Home Aide Service Log must be signed by the recipient. The recipient must be instructed to sign the log only after the services are delivered. If the recipient is only able to make a mark, the in-home aide must document that this is the patient's mark and sign this statement on the service log. A recipient's relative, friend or neighbor may also serve as a witness. **If a telephonic recordkeeping system is used by the provider, recipient records must meet the specifications listed in Section 7.10.**

7.11 Recordkeeping Requirements

7.11.1 Minimum Requirements

The following are minimum requirements for recordkeeping for PCS services:

1. Clinical records and billing documentation must be kept for a minimum of five years.
2. The PCS provider must be able to supply the following signed documents to support services billed to the Medicaid program:
   a. **PCS PACT Form and Plan of Care**: Retain the completed, signed and dated PCS PACT Form and plan of care.
   b. **Supervisory Notes**: Retain RN supervisory notes documenting the RN supervision visits in accordance with PCS policy timeframes and requirements.
   c. **PCS In-Home Aide Service Logs**: Retain aide notes and/or service logs documenting time in and out, tasks completed and time billed.

7.11.2 Electronic Records

A PCS provider may store clinical records, including PCS assessment information, and health insurance records electronically (i.e., disk, microfilm, or optical imaging systems). Providers using electronic storage systems are subject to following recordkeeping requirements:

Electronic clinical records and electronic billing documentation must be kept for a minimum of five years.

1. The provider must be able to promptly retrieve the records and make them available for review by DMA or agents acting on behalf of DMA for bill review, audit, or other examination during the retention period specified above. The PCS provider must be able to supply the following electronic copies of signed documents to support services billed to the Medicaid program:
   a. **PCS PACT Form and Plan of Care**: Retain the completed, signed and dated PCS PACT Form and plan of care.
   b. **Supervisory Notes**: Retain RN supervisory notes documenting the RN supervision visits in accordance with PCS policy timeframes and requirements.
   c. **PCS In-Home Aide Service Logs**: Retain aide notes and/or service logs documenting time in and out, tasks completed and time billed.
2. With respect to bill review, audit, or other examination, clinical records must be presented along with the equipment necessary to read them.
3. All documentation with electronic signatures must be consistent with federal regulations, the N.C. Rules Governing the Licensure of Home Care Agencies, rules and regulations promulgated by the North Carolina Boards of Medicine and Nursing, and agency policy.
4. Providers utilizing telephonic recordkeeping systems must maintain documentation according to the requirements specified in **Section 7.10**.

7.11.3 Facsimile (Fax) Signatures

Fax signatures may be used if they are consistent with the N.C. Rules Governing the Licensure of Home Care Agencies, rules and regulations promulgated by the North Carolina Boards of Medicine and Nursing, and agency policy.

7.12 Telephonic Standards and Requirements

If a PCS agency intends to implement a telephonic recordkeeping system, the system must meet the criteria established by DMA and delineated below. The criteria must be met through a combination of electronic and paper records.

7.12.1 System Requirements

1. The system must record the exact arrival and departure times with the following quality assurance filters:
   a. Verify the recipient phone number (residence or recipient specific number).
      Note: The recipient must be present in the home during the visit.
   b. Verify the employee with a unique/secure identification number.
   c. Identify calls made from an alternate/non-authorized number.
   d. Maintain data according to the same standards for recordkeeping listed in **Section 7.10 and 7.11**.
   e. Data entered into the system must be retrievable according to the same standards for recordkeeping listed in **Section 7.11.2**.
   f. Verify program and recipient present and services provided. The provider may use a combination of electronic and "paper records" as long as all required record components are present and retrievable by the provider.
   g. The system must meet HIPAA-mandated regulations for electronic transactions.
2. Security measures must be implemented to:
   a. prevent manipulation or alteration of the entries;
   b. allow the capability to verify the location of the call, the employee placing the call, and the services provided; and
   c. Allow for the capability to screen calls made from unauthorized locations.
3. A secure manual override process may be implemented to accommodate occasional personal error of staff that are unable or fail to log into the system. The override process must follow an established, written process with oversight to protect the system.
4. The system data must be accessible and the provider must be able to retrieve data consistently and to produce a hard copy of the data.
5. The provider must be able to locate the employee using the system.
6. An alternate hard copy system must be available to use in the event that there is no functioning phone available or if there is a local disaster/emergency.

7.12.2 System Standards

1. The recipient's name, Medicaid identification number, the time that the employee arrived and the time that the employee departed must be recorded and/or entered into the system along with location verification, day of the week, the recipient's presence, medical monitoring, and the type of services (tasks) provided.
2. The call must be placed at no cost to the recipient.
3. There must be evidence of written permission for the agency staff to use the phone for the purpose of recordkeeping.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2001

Revision Information:

Date	Section	Change
All changes are effective as of 11/1/05, *except as indicated in the separate implementation schedule*	Section 1.0	Services must be linked to the identified need and medical condition and must be authorized by the primary MD or PA/NP working under MD supervision.
	Section 2.2	Adds special provision for recipients under the age of 21.
	Section 3.2	Service must be directly related to medical condition, be medically necessary and be identified in the PCS PACT-plan of care. Adds: If the recipient does not receive the service the medical condition will deteriorate.
	Section 3.2.1	Minimal requirement set at 2 ADL needs, tasks are identified in the PCS PACT and there must be no other family members available who can meet the need(s). Recipient must not be able to do the task independently and task must be included in the POC.
	Section 3.2.2	Defines medically stable
	Section 3.3	Adds specific examples of coverage criteria for pregnant women and cross references to the prior approval process
	Section 3.4	Adds clarification specific to the coverage of infants and children and requires linking need to the medical condition and disallows if needs are parental responsibility or are not age appropriate.
	Section 4.6	Clarifies non-covered services such as school transportation, homework assistance, pet care, yard work, and housework for other household residents.
	Section 5.1	Updates the reduction in hours from legislated change in 2002; adds PCS-Plus provisions from 2003
	Section 5.4	Identified and defines the covered tasks.
	Section 5.4.1	Provides time guidance in developing plan of care
	Section 5.4.2	Identifies mechanism for time exemption
	Section 5.5	Identifies delegated monitoring tasks.

Revision Information, continued

Date	Section	Change
All changes are effective as of 11/1/05, *except as indicated in the separate implementation schedule*	Section 5.7	Identifies home management tasks and links to medical need and POC, addresses economy of tasks in multi-recipient homes, defines essential errands, limits bill paying to utilities and addresses the expectation for aide to multi-task.
	Section 6.1	Home care license must be current.
	Section 6.2	Must have a separate and distinct provider number for each site and use the number in billing. Must submit a cost report.
	Section 6.3.1	RN must successfully complete DMA approved certification training.
	Section 6.3.2	In-home aides must meet DFS licensure specifications.
	Section 7.1	Clarifies MD authorization for assessment. Prohibits the direct solicitation of clients for services. Requires documentation of verbal orders. Requires signature by physician of verbal orders within 60 days. Provides process for use of fax/electronic signatures.
	Section 7.2	Requires signature of physician on PACT within 60 days of order for assessment.
	Section 7.3	Clarifies assessment and reassessment requirements.
	Section 7.3.3	Requires reassessment after a lapse in service for more than seven service days.
	Section 7.3.4	Requires reassessment when there is a significant change in recipient's condition. Identifies additional indicators for RN supervisor to detect changes in recipient's condition.
	Section 7.4.1	Requires the use of the PCS PACT form.
	Section 7.4.2	Requires certification and attestation by RN assessor.
	Section 7.7	Notes the shared responsibility by RN, physician and provider for assuring the accuracy of the assessment and the plan of care. Requires the provider to initiate POC within 14 calendar days.
	Section 7.8.1	Requires POC change if recipient's needs require an increase or decrease by 60 minutes or more per week in the total assigned time.
	Section 7.8.2	Defines non-significant changes.
	Section 7.8.3	Requires POC revision when PCS-Plus is prior approved to account for the additional time and tasks in PCS Plus.
	Section 7.9	Supervision frequency is changed from 60 to 90 days. Identifies the required elements of a supervisory visit.
	Section 7.11.2	Provides a mechanism for the use and storage of electronic records.
	Section 7.12	Establishes the criteria telephony systems including system standards and security requirements.
	Attachment A	Adds wage and hour requirements for rounding billing units (7/8 rule).

Revision Information, continued

Date	Section	Change
All changes are effective as of 11/1/05, *except as indicated in the separate implementation schedule*	Attachment B	Provides task definitions and time guidance for both personal care and home management tasks.
	Attachment C	Outlines a QA program that will be a component of the global DMA plan and consistent with CMS standards in the Domains of Quality. Defines the shared responsibility of all stakeholders. Establishes a program for agency self audit, targeted record reviews, educational reviews and focus studies.
	Attachment D	Provides a suggested format for studying the key aspects of services.
	Attachment E	Provides an acceptable example of an agency policy regarding the reassessment of clients for services.
	Attachment F	PACT is required form for PCS assessment and authorization.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.

Attachment A: Claims Related Information

A. Claim Type

- Q, UB-92 (end date July 31, 2004)
- J, CMS 1500 (effective August 1, 2004)

B. Diagnosis Codes

A valid ICD-9-CM code that supports the medical necessity of service must be used. Diagnosis codes beginning with V (example: V700) are not acceptable and will result in a denial of the claim.

C. Procedure Code(s)

PCS	RC599 (end date 7/31/04)
PCS	S5125 (effective date 8/1/04)
PCS-Plus	RC599 with prior approval (end date 7/31/04)
PCS-Plus	99509 (effective date 8/1/04)

D. Reimbursement

- Providers must bill usual and customary charges.
  1 unit of service = 15 minutes
  Maximum allowable rate = a rate calculated by DMA and based on costs
  Maximum units allowed for PCS = 14 units/day and 240 units/month
  Maximum units allowed for PCS-Plus = 320 units/month
- PCS follows wage and hour requirements for rounding billing units (7/8 rule)

E. What May be Billed

PCS providers may bill for the following when accomplished according to Medicaid policies and procedures and documented in the recipient's records:

- The time that the RN spends at a recipient's residence for the initial assessment, annual reassessment, and reassessment when a change in the recipient's condition occurs.
- The time the RN spends at a recipient's home for supervisory visits.
- The time the PCS in-home aide spends at a recipient's residence providing the authorized personal care and related home management tasks.
- The time the PCS in-home aide spends away from a recipient's residence to perform essential errands (refer to **Attachment B**) for the recipient according to the plan of care.

Attachment B:
Time Guidance for Personal Care and Home Management Tasks

Recommended time guidance to assist in the development of the plan of care for each task is listed below. All NA 1 Tasks must be performed as indicated by client needs. If the recommended time guidance does not allow adequate time to complete a personal care task for a recipient, the RN must document the need for a time exception on the PCS PACT Form or other supporting documents.

Personal Care Task	DMA Time Guidance ***Exact time for each task must be specified on the PACT POC. The range provided allows the provider to base the time on individually assessed client need.***
Bathing	
Taking a Full-body Bath: Tub, shower or sponge/bed bath. Transferring in and out of tub and shower. Exclude washing hair, back or foot care.	Up to 30 minutes daily. May rotate with partial bath based on recipient's needs.
Partial Bath: A sponge bath includes, at minimum, bathing of the face, hands, and perineum. Bathing of the feet may be done on limited days recognizing a full daily shower is not needed for an aging and non-ambulatory recipient.	15-20 minutes/partial bath. Plan should have a partial bath o*nly* as a component of care, rotating with a full body bath.
Foot care/washing back, hands or face alone does not meet the bathing description/criteria. Foot care is defined as soaking feet, applying lotion to the feet, and toenail care. Foot care does not qualify the client for PCS.	15-20 minutes/day
Dressing	
Laying out clothing, handing and retrieving clothing, putting clothes on and taking them off, including handling fasteners, zippers and buttons.	15 minutes/day
Application of prosthetic devices or application of therapeutic stockings.	May add 15 minutes for applying hose and/or prosthesis/day.
Grooming/Skin Care	
Brushing teeth, denture care, shaving, washing and drying face and hands. Applying lotion to non-broken skin.	15-30 minutes/day
Shampoo and comb hair, basic hair care, basic nail care.	15 minutes/event
Bed Mobility	
Moving recipient to and from a lying position, turning side-to-side and positioning recipient in bed.	10 minutes/every 2 hours when not related to a personal care activity
Transfer	
Moving recipient to and between surfaces: Bed, chair, wheelchair, and standing position. May include the use of assistive devices such as Hoyer lift, transfer or slide board, gait belt, or trapeze. Standing/Pivot transfer.	15 minutes/every 2 hours when not related to a personal care activity

Personal Care Task	DMA Time Guidance
Ambulation	
Moving in the recipient's residence: To and from bathroom, bedroom, kitchen and dining area, living/sitting area, outside (porch, deck, yard). May use assistive devices including cane, walker, and wheelchair. If wheelchair bound, requires assessment of self-sufficiency to perform ADLs once in wheelchair.	15 minutes/day. This would be added when the recipient, at a minimum, needs hands-on and/or standby assistance. If the recipient is ambulatory, with or without an assistive device, a score of 0-1, no time is budgeted for this task.
Toileting	
Using the toilet: How the individual uses the toilet including transfer on/off the toilet, bedside commode, urinal and/or bedpan. Includes cleaning the perineum, cleaning after an incontinent episode and frequency of urinary and BM incontinence, changing incontinent devices such as diapers, disposable underwear, and pads. Managing special devices such as ostomy care and catheter care (including emptying the catheter bag).	15-45 minutes/day. Time at the highest end supported by incontinent episodes and mobility limitations.
Eating	
Taking in food by any method. Oral intake of food: May include supplements, special diets, and tube feedings. Patient may require set up, hands-on assist with feeding, supervision with eating, complete feeding, and tube feeding (bolus). Meal prep is a companion instrumental ADL (IADL). Extra time may be allowed for preparing a special diet including chopped, ground, or pureed supplements.	30 minutes to feed/meal. If recipient feeds self independently and the activity is meal preparation, it is considered an IADL and time must be budgeted under home management.
Delegated Medical Monitoring and Activities	
Non-skilled medical tasks which are delegated to the in-home aide by the RN, in accordance with N.C. laws, practice acts, standards of care, and agency policy. The tasks include, but are not limited to: assisting recipient with pre-poured medications, assisting with FCBS, monitoring vital signs (temperature, blood pressure, respirations and pulse), measurement of intake/output, and agency approved NA II tasks (per NC Board of Nursing regulations).	15-30 minutes/day for all monitoring tasks performed. Less time needed for a single task. If the activity does not occur during the aide's shift, no time can be budgeted. For example, if a family member provides medication administration or the activity does not occur during the scheduled visit.
Treatment	
Range of Motion exercises Other NA I approved tasks as per NC Board of Nursing regulations and adopted by reference. NA II approved tasks as per NC Board of Nursing regulations and adopted by reference.	15-30 minutes/day

Personal Care Task	DMA Time Guidance
Other Medical Considerations	
Other medical considerations that may affect the amount of time allocated to a personal care task include the following, but are not limited to: dyspnea, shortness of breath with minimal exertion, continuous use of oxygen, medication assistance, incontinence needs, and endurance or pain issues. Cognitive impairment causing the recipient to require extensive hands-on assistance with a personal care task may also affect the amount of time allocated to a personal care task. This is shown by lack of alertness, and orientation, or inability to shift attention and recall directions more than half of the time.	Additional time, as per individual need.

The PCS aide may also complete the In-Home Aide Level I and Level II home management tasks identified in the table below when the task is related but incidental to the recipient's personal care needs. Housekeeping and home management tasks must be essential, although secondary to the personal care task necessary for maintaining the recipient's health, and directly linked to his/her medical condition and personal care needs. The tasks are meant to be completed for the recipient only, not others living within the household. Weekly home management task time should never exceed weekly personal care task time.

- Staff is expected to do multiple tasks at a time. For example, while the laundry is in the washer, the aide could be preparing a meal and performing other home management tasks.
- Linen change, mopping, laundry, etc. are not to be performed daily. Some tasks such as washing dishes, food storage and making the bed may be performed daily. Thus, the time allotted in the plan of care should reflect daily needs of the recipient. Specific documentation must be provided to identify need and support tasks that are to be provided more frequently. For example, more frequent linen changes and laundry for an incontinent patient.

Home Management Tasks	DMA Time Guidance *See above explanation regarding frequency of tasks.*
***Meal Preparation for Meals and/or Snacks*:** Simple diet, therapeutic modifications (low sodium, heart healthy, diabetic). Plan menus using food guide.	30-45 minutes/meal
Modified Diet for Meals and/or Snacks: Chop, puree, grind, cut, serve, wash dishes, food handling and storage. Clean kitchen after meal, sweep and mop, take out trash.	Additionally to the above time guidance, 30-60 minutes/day
Recipient Bathroom: Clean sink, toilet, tub/shower.	15-30 minutes
Recipient Laundry: Wash, dry, fold, simple mending, press.	30-60 minutes
Recipient Bedroom: Make bed, change linen, vacuum, dust, tidy living areas.	15-30 minutes
Recipient Living Areas: Tidy, keep free of clutter, dust, sweep/vacuum, sweep pathways.	15-30 minutes
Run Essential Errands for the Recipient: Pharmacy, medical supplies, groceries, pay utility bills, and shop for other essential medical care items.	45-60 minutes

Other Covered Home Management Tasks:

- Basic reading and writing tasks for recipients with an identified and documented need. For example, when the client is blind.
- Other miscellaneous tasks: Complete basic housekeeping tasks, including sweeping, vacuuming, dusting, mopping, and washing dishes for recipient **only**, separate from other members of the household.
- Observe and report symptoms of abuse, neglect, and illness to RN clinical supervisor who is required to report to the county DSS Protective Services for investigation as required by GS 108-A, Section 6.

Attachment C:
Quality Assurance and Utilization Management Program For Medicaid In-Home Personal Care Services

The Division of Medical Assistance (DMA) and Medicaid providers have a shared responsibility for assuring that in-home personal care services (PCS) are a quality service and provided to Medicaid recipients in accordance with program policies. The PCS Quality Assurance and Utilization Management (QA/UR) Program provides a system for all who have a stake in the quality of personal care services. This system provides a framework to achieve the desired recipient outcomes in the seven domains of quality as defined by the Centers for Medicare and Medicaid Services (CMS). The QA/UR program addresses key aspects of service including: assessment, service planning, monitoring, recipient safety and welfare, rights, critical safeguards, and provider qualifications/administrative responsibilities. These key aspects will provide a foundation to design strategies, collect data and assess the implementation and operation of the PCS program, identify concerns and problems and remedy any identified problems. The QA/UR system will evolve and continue to address identified areas for improvement as it moves forward to continually improve the quality of PCS services. The seven domains of quality used for focus are: participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes, and satisfaction and system performance.

Provider Quality Assurance and Utilization Management Program

As stated in the N.C. Rules Governing the Licensure of Home Care Agencies (10A NCAC 13J.1004) and adopted by reference:

> An evaluation of the agency's recipient records shall be carried out at least quarterly by appropriate professionals representing the scope of the agency's program. The evaluation shall include a review of sample active and closed recipient records to ensure that agency policies are followed in providing services, both direct and under arrangement, and to assure that the quality of service is satisfactory and appropriate. The review shall consist of a representative sample of all home care services provided by the agency.

Additionally, the evaluation shall address a minimum set of items designed to study the key aspects of services. A suggested format with the minimum data set items are shown in **Attachment D**. The aspects of services studied will be continually revised as areas for improvement are identified. An agency may select to use this tool or build upon the key aspects of service outlined.

The PCS quarterly review of PCS Medicaid recipient records performed by the PCS provider's personnel will help identify problems immediately allowing the provider to implement corrective action plans that will improve the quality of services and compliance and prevent additional state interventions. The quarterly review of 10% of the PCS records (or 10 whichever is less), including open and closed records, by the provider's personnel may target the following:

- ***Person-centered/access:*** Documentation of the recipient's medical need and the related ADL deficits for the service/appropriateness for service.
- ***Person-centered /access:*** Assessed needs support for the amount and duration of service provided. The amount of service is consistent to meet the recipient's identified needs.
- ***Person-centered:*** The services authorized meet identified needs, are revised as the recipient's needs change and are evaluated by a qualified RN supervisor.

- ***Outcome:*** The services provided are in accordance with the services authorized by the physician/plan of care.
- ***Outcome:*** The recipient outcomes are appropriate and recipient's perception of services is provided.
- ***Rights/responsibilities:*** Grievance process is in place and complaints are heard and investigated, and discharge notice is appropriate and consistent.
- ***Safeguards:*** Provider incident and performance improvement is in place, including critical incident reporting (sentinel event/hazardous events).
- ***System performance:*** The provider implements a quality program to monitor the services, respond to identified concerns and maintain financial integrity.

Consistent with the quarterly review required by the N.C. Rules Governing the Licensure of Home Care Agencies, PCS providers that participate in the Medicaid PCS program must implement additional targeted quality assurance and utilization management (QA/UR) monitoring to ensure that policy is implemented.
Examples of aspects of service monitored are:

- Recipients meet DMA's medical criteria to qualify for the service; with complete DMA standardized documentation and a physician signed plan of care.
- Recipients receive the services recorded/documented in the plan of care/authorized services.
- Services are supervised every 90 days, as required, by a licensed registered nurse (RN) and twice a year with the aide present during the visit.
- Services are evaluated to: determine individualized recipient needs, including but not limited to, the recipient's safety and welfare. Based on the evaluation and as the recipient's needs and condition change, services are updated.
- Medicaid billing is accurate with supporting documentation showing times and days care provided, tasks completed as authorized, supervised as indicated.

There are many methods that PCS providers can use to review or monitor the recipient's needs and assure that Medicaid PCS services are provided in accordance with the care plan. Examples include: surveying the recipients by periodic telephone calls, monitoring during required home supervisory visits to reassess the recipient condition and needs, evaluating the performance of the aides, using the electronic check-in and check-out systems to validate aide services, and reviewing PCS In-Home Aide Service Logs or flow sheets, and incident/complaint management.

The provider self-audit is reviewed within the agency. During a state level review, the DMA staff will request the self-audit, findings and the plan to address the findings. The DMA may request that a copy of the audit be submitted in a DMA PCS desk review.

Participation in the self-audit program does not remove the possibility of further review by DMA Program Integrity (or other DMA authorized agents) in current or future review activities deemed necessary to ensure program compliance or to pursue administrative civil or criminal remedies.

Provider capacity and capability: The QA/UR monitoring will require the PCS provider's registered nurse(s) who performs the initial and subsequent assessments of the recipient and establishes the plans of care to successfully complete a DMA-approved PCS certification training. The training is specifically designed for PCS nurses who will be completing assessments and supervising PCS. Providers are also required to complete administrative responsibilities such as required reporting of agency changes and submitting cost reports to DMA.

State Quality Assurance and Utilization Reviews

Educational visits: Newly enrolled PCS providers may be subject to an on-site educational review from DMA staff.

All Enrolled Medicaid PCS Providers

Targeted record reviews: DMA may draw a sample of PCS recipients for review by DMA staff or its contractor. DMA may elect to draw a random sample or a targeted sample for focused reviews. (Examples include, but are not limited to, more than one PCS recipient residing in the same home, pediatric PCS services, or recipients with a specific diagnosis). The sample will be drawn within acceptable guidelines. The provider will receive by fax or electronic means the recipient's name, Medicaid identification number, dates of service, a list of the information needed by DMA and a due date for the information to be returned to DMA or its contractor.

The state level reviews will consist of desk reviews of provider records and/or an on-site validation review of the recipient and records by a registered nurse. The review may include:

- Person centered: the recipient's medical information supports the receipt of Medicaid PCS.
- Outcome: the amount (hours) of PCS and/or the duration of services authorized are provided in accordance to the time guidance and identified ADL needs.
- Person centered: the plan of care is based on identified needs/ADL deficits.
- Outcome: recipient perception of services, supervision evaluates ongoing need, appropriateness, service provision and feedback, and the plan is updated to meet the changing needs of the recipient.
- Rights: recipient complaints are heard and investigated according to licensure standards, recipients have a choice in service, setting (home vs. facility, provider coordination).
- Safeguards: recipients are protected with prompt investigation of any abuse, neglect, exploitation, misappropriation of recipient or company property, including DSS Protective Services reporting, Health Care Personnel Registry (HCPR) reporting, and incident management.
- System performance: billing codes are appropriate, documentation supports billing. DMA or its contractor may request additional information from the provider if needed to conduct the review.
- Provider capabilities: enrolled provider has a current license, files cost reports in a timely manner, communicates required provider information as specified in the enrollment agreement. Skills and training – RN has completed the DMA PCS certification training.

Implementation of the QA/UR Program

During the first year of the QA/UR program, the results of the state level reviews will be sent to the PCS provider along with any recommendations for improvement.

At anytime, DMA will recoup errors, not limited to:

- ***Payments made for services not provided.***
- ***Payments made when there is no documentation to support service provision.***

DMA Program Integrity will continue to investigate complaints and allegations of fraud and/or program abuse in a separate review process, as is current practice.

If errors or discrepancies are found through the QA/UR program that indicates the recipient does not meet Medicaid PCS criteria, written notification advising reassessment of the recipient to determine continued appropriateness for services is sent to the provider and copied to the recipient's primary physician.

The findings from the state level validation reviews will be given to the PCS provider in the form of a written report. DMA findings on errors could result in recoupment of Medicaid PCS payments.

The QA/UR plan will be reviewed and continually revised as needs and areas for improvement are identified. The plan is a segment of the Division of Medical Assistance overall Continuing Quality Initiative.

Attachment D: State Quality Assurance/Utilization Review

State Quality Assurance /Utilization Review **Monitors for Key Aspects of PCS** **DMA Utilization Review Tool** **Date:** **Agency:** **Auditor:** **Sample Size:** **Goal – notes desirable outcome** **Ut –unacceptable threshold, PI reports * at DMA validation review**			**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**MID/Initials**	**Total %**
Area of Review	**Answer**	**Goal**											
RN Assessment /Authorization for Services													
PCS PACT documents medical condition related to need for PCS.	__Yes __No	G 100% Ut 70%											
Deficits in activities of daily living (ADL) are based on medical condition (bathing, grooming, toileting, transfer, ambulation, eating).	__Yes __No	G 100% Ut 70%											
Recipient assessment supports ADL deficits and identified needs.	__Yes __No	G 100% Ut 70%											
Recipient rights reviewed and documented.	__Yes __No	G 100% Ut 70%											
PCS PACT signed by physician within 60 days of the verbal or recorded order.	__Yes __No	G 100% Ut 70%											
PCS PACT/assessment completed by PCS certified RN.	__Yes __No	G 100% Ut 70%											

RN Assessment /Authorization for Services, continued													
Hours are consistent with identified needs (time and task guidance or exception documented).	__Yes __No	G 100% Ut 70%											
Plan of Care													
Days/times based on tasks/needs.	__Yes __No	G 100% Ut 70%											
Plan of care based on ADL deficits/identified needs/tasks and are included in the plan.	__Yes __No	G 100% Ut 70%											
Instrumental ADL (IADL) based on medical condition/ADLs/identified needs.	__Yes __No	G 90% Ut 70%											
Service Notes													
Tasks in plan of care documented on daily service notes.	__Yes __No	G 100% Ut 70%											
Deviations to the plan or schedule are documented.	__Yes __No	G 100% Ut 70%											
Times/days match plan of care/authorization.	__Yes __No	G 100% Ut 70%											
Service Management													
Client satisfaction/perception of services documented.	__Yes __No	G 90% Ut 70%											
Supervision is timely (every 90 days and unplanned lapses).	__Yes __No	G 100% Ut 70%											

Service Management, continued													
Supervision meets standards: • condition, • continued service need, • update plan as needs change	__Yes __No	G 100% Ut 70%											
Follow up to complaints is conducted in accordance with Division of Facility Services (DFS) requirements and agency policy.	__Yes __No	G 100% Ut 90%											
Discharge/reason and needs noted.	__Yes __No	G 100% Ut 70%											
Discharge notice given (48 hours), if applicable.	__Yes __No	G 100% Ut 80%											
Medicaid Provider Enrollment													
Authorization signature is current and on file with DMA.	__Yes __No	G 100% Ut 90%											
Changes in address/phone reported to DMA.	__Yes __No	G 100% Ut 80%											
Changes in leadership reported to DMA.	__Yes __No	G 100% Ut 80%											
Individual provider number used for each licensed site.	__Yes __No	G 100% Ut 80%											
System Performance													
DFS license is current and valid.	__Yes __No	G 100% Ut 90%											
Audits reviewed and in good standing or plan of correction implemented, if applicable.	__Yes __No	G 100% Ut 80%											

Performance Improvement Program													
Agency (self-audit) record reviews are current/complete.	__Yes __No	G 100% Ut 80%											
Agency complaint management system is current and implemented.	__Yes __No	G 100% Ut 80%											
Finance/Billing													
Cost reports are complete and submitted timely to DMA.	__Yes __No	G 100% Ut 90%											
Services billed reconcile with authorized and provided services.	__Yes __No	G 100% Ut 70%											

Attachment E:
Example of Home Care Provider Policy for PCS Reassessments

Policy: All recipients receiving personal care services (PCS) will have periodic reassessments completed at least every 365 days and following a hospitalization/institutionalization with a significant change in their condition or when they have significant changes in condition.

Purpose: To ensure that PCS services provided by the agency are appropriate and adequate to meet recipient needs.

Procedure:

1. All PCS recipients must have a comprehensive initial assessment. The assessment will be updated, and the PCS Physician Authorization for Certification of Treatment (PACT) revised as frequently as the recipient's condition warrants due to a major decline or improvement in health status.

2. Reassessments must be conducted in the recipient's residence *(except as provided in Section 7.3.3 of DMA PCS Policy No. 3C)*, face-to-face with the recipient, and must be conducted as follows:
   a. every 365 days beginning with the start of care date;
   b. prior to restarting personal care services after a hospitalization/institutionalization that created a change in the recipient's functional health status or indicated a new primary diagnosis;
   c. when an unplanned service lapse of more than seven days has occurred;
   d. upon the investigation of a recipient complaint that involves abuse, neglect or exploitation of a recipient or a substantial care complaint; and/or
   e. a change in service location (e.g., recipient moved).

3. PCS recipients are evaluated with each supervisory visit to validate that the care plan is appropriate (by determining if the recipient's condition is stable, if a comprehensive assessment is indicated, if the care plan needs to be revised including an increase or decrease in services) and to ascertain the recipient's perception of care.

4. The PCS certified registered nurse (RN) will update and revise the assessment/PCS PACT as frequently as the recipient's condition warrants due to an unanticipated major decline or improvement in the recipient's health status that requires a new physician authorization, such as a change in the plan of care of more than one hour in the weekly service total or addition of a medical or pharmaceutical regimen.

   - Major decline: a significant exacerbation in the recipient's condition as indicated by a new primary diagnosis or change in treatment such as the implementation of a new medical and pharmaceutical regimen in conjunction with the new diagnosis onset or exacerbation. Examples would include the addition of any approved Nurse Aide II Task to the care plan, delegating a medical treatment or medical monitoring, a request for PCS-Plus services based on new needs or change in functional health status/activities of daily living (ADL), a change in the recipient's health status from chronic to acute level of care, a change which affects the scoring of the ADLs from limited assistance to extensive assistance in two categories, RN review of the service notes indicating a trend that the in-home staff is not providing the care in accordance with the plan of care, and/or the addition of a "Do Not Resuscitate (DNR) Order."

- Major Improvement : A significant unanticipated improvement in the client's health status and the client's needs and complexity of condition has significantly decreased, the decrease in services of more than one hour in the weekly total, an improvement in functional health status/scoring of ADL self performance from extensive assistance/dependent to limited assistance or supervision of activity.

5. A new PCS PACT must be completed, at a minimum, annually as well as a thorough review of the recipient's condition, functional health status with limitations in ADL status assessed, and the care plan.

Attachment F: PCS PACT Form

Annual Certification Due:_____

PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

Referral Date:_____ Date Initial Assessment Completed:_____ Date Last Reassessment Completed:_____

Provider Name:_____ PCS Provider #:_____ Provider Phone #:_____

Provider Address:_____

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME:_____
2. MEDICAID ID # (MID):_____ 3. SOCIAL SECURITY# _____
4. PATIENT ADDRESS:_____
5. PATIENT PHONE:_____ 6. SEX: ☐Male ☐Female 7. DATE OF BIRTH (mm/dd/yy):_____
8. PATIENT LIVES: *Check all that apply* ☐Alone ☐w/Spouse ☐w/Adult Child(ren) ☐w/Parent(s) ☐w/others
9. CONTACT PERSON'S NAME:_____ RELATIONSHIP TO PATIENT:_____
   ADDRESS:_____ PHONE: (H)_____ (W)_____
10. ATTENDING PHYSICIAN'S NAME:_____ PHONE:_____
    ADDRESS:_____
11. DATE OF MOST RECENT EXAM (mm/dd/yy):_____ 12. Vital Signs @ Assessment: B/P____ T___ P___ R___ Wt___ Ht___
13. REASON FOR REFERRAL:_____ Referral Source:_____
14. DIAGNOSIS (Specify date of onset and ICD-9 code):_____
15. CURRENT CARE (Type and Source):_____

ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (Name/Dose/Frequency/Route)

17. Self-Administered? ☐Yes ☐No If no, who assists? (Name/Relationship)_____ Reminders needed? ☐Yes ☐ No

18. Does the individual have any allergies?: ☐ No Known Allergies ☐ Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:

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PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

Limitations in Activities of Daily Living (ADLs)

Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below. Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task. M=Mon T=Tues W=Wed Th=Thurs F=Fri S=Sat Sun=Sunday

A. ADL Self-Performance Scores

0. INDEPENDENT: No help needed or oversight needed.
1. SUPERVISION: Oversight, encouragement, or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives hands-on help in *guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene self monitoring of meds and / or* other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, substantial or consistent hands-on assistance *with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and /* or weight bearing assistance is needed.
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores

0. No set-up or physical help needed 1.Set-up help only 2.One person physical assist 3.Two+ persons assist and/or one person assist w/assistive equipment

			A. ADL Self-Performance	B. ADL Support Provided	Place a check in the box if assistance is needed
19.	**Ambulation:**	Note assistive equipment patient is to use while ambulating: ☐Cane ☐ Quad cane ☐Walker ☐ Bed/chair bound ☐other _____			
20.	**Non-ambulatory/ Transfer:**	Moving to and between surfaces: bed, chair, wheelchair, standing position. Note assistive equipment patient is to use during transfer: ☐ Manual wheelchair ☐ Electric wheelchair ☐Hoyer lift ☐Transfer Board ☐Trapeze Bar ☐ other _____ Note self sufficiency once transferred _____			
21.	**Nutrition:**	*Check assistance needed with taking in food by any method.* ☐Oral ☐Parenteral ☐ Tube_____ ☐Feed patient ☐Set-up only Dietary Restrictions_____ Supplements_____ Diet Ordered_____ Meal Prep: ☐ 1 meal_____ ☐ 2meals_____ Kitchen cleanup (cleaning table, stove, washing dishes, putting away items used, sweeping)_____			
22.	**Respiration:**	☐Normal ☐Dyspneic with minimal exertion ☐Tracheostomy ☐Mechanical Oxygen: ☐Continuous ☐Intermittent ☐Nebulizer Treatments _____ A. Dust_____ B. Vacuum_____ C. Mop_____ D. Sweep_____			
23.	**Endurance:**	☐Pt. is never short of breath (SOB) ☐Pt. is SOB when walking more than 20 feet or climbing stairs ☐Patient is SOB when walking less than 20 feet and or dressing self or using commode ☐Pt is SOB w/minimal exertion (i.e. eating, talking, performing ADLs, agitation) ☐Pt is SOB at rest ☐Pt has generalized weakness A. Change bed linens_____ B. Make bed_____ C. Grocery shop_____ D. Pick-up medicine_____ E. Pay utility bills _____ F. Take out garbage_____ ☐Check smoke alarm: ____			
24.	**Skin:**	☐Normal ☐Dry, cracked or bleeding areas ☐Pressure areas ☐Decubiti A. Diabetic foot care required?: ☐Yes ☐No Freq:_____ B. Nail Care?: ☐Yes ☐No Freq:_____			
25.	**Bathing:**	A. Taking full body bath_____ B. Shower_____ C. Sponge bath_____ D. Shampooing hair_____ E. Clean bathroom after bathing_____ ☐ Transferring in and out of tub and shower *Devices needed:* ☐ Shower bench ☐ Bath Safety Bars ☐Detachable shower head			
26.	**Personal hygiene:**	☐Combing hair ☐Brushing teeth ☐Cleaning dentures ☐Washing/drying face and hands and perineum A. Braiding or setting hair_____ B. Shaving_____			
27.	**Dressing:**	☐Laying out clothes ☐Retrieving clothes from closet ☐Putting clothes on and taking clothes off ☐Donning/removing TED Hose ☐ Donning/removing prosthesis A. ROM_____ B. Launder pt's clothes, bed linens, towels, and washcloths_____			
28.	**Bladder :**	*Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self.* ☐Normal ☐Ileostomy ☐Indwelling catheter ☐Condom Catheter ☐Occasional incontinence (less than daily) ☐Daily incontinence ☐Incontinence during the day and night *Devices/supplies needed:* ☐ Bed/chair bound ☐ Bedside commode ☐ Elevated Toilet Seat ☐ Bedpan ☐Urinal ☐Pads ☐Diapers ☐Cath Care			
29.	**Bowel:**	*Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self.* ☐Normal ☐Occasional Incontinence (less than daily) ☐Daily incontinence ☐Constipation ☐Ostomy *Devices/supplies needed:* ☐Bedside Commode ☐ Elevated Toilet Seat ☐Bedpan ☐ Pads ☐ Diapers ☐Enemas_____ ☐Bowel Program_____			
30.	**Self-monitoring:**	Self-monitoring of: ☐ Pre-poured medications ☐ Blood Sugars: Notify MD if BS is above_____ or below_____ BP: Notify MD if BP is > _____ or < _____ ☐ Weight: Notify MD if pt. loses or gains ____lbs. within ____days.			

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

Other Client Information

Check the appropriate box if it applies to the patient.

31.	**Pain:** *7-day look-back*	Location of pain_____ Severity of Pain: *Rate 0 – 10: 0=no pain and 10=worst pain* _____ Pain frequency: ☐No pain ☐Pain < daily ☐Pain > daily Pain control: ☐No pain ☐Pain improved with medication ☐No pain relief or improvement w/medication
32.	**Cognitive Skills for Daily Decision Mkg:**	☐Independent (decisions consistent/reasonable) ☐Modified independence (some difficulty in new situations only) ☐Moderately impaired (decisions poor, cues/supervision required) ☐Severely impaired (never/rarely makes decision) ☐Patient requires step-by-step verbal prompting ☐MR/DD _____ (level)
33.	**Behavior:**	☐Cooperative ☐Passive ☐Physically abusive ☐Verbally abusive ☐Wanders ☐Injures self/others/property ☐Non-responsive
34.	**Vision:**	☐Adequate for daily activities ☐Limited (sees large objects) ☐Very limited (blind) *Client uses:* ☐Glasses ☐Contacts
35.	**Hearing:**	☐Adequate for daily activities ☐Hears loud sounds/voices ☐Very limited (deaf) *Client uses:* ☐Hearing aids
36.	**Speech:**	☐Normal ☐Slurred ☐Weak ☐Other impediment: specify_____ Primary Language(s)Spoken_____
37.	**Communication Method:**	☐Speech ☐Gestures ☐Writing ☐Assistive Device: specify type _____ ☐ Client unable to write; have client make mark here: _____ Nurse's initials: _____

38. ☐ Additional time needed. Document here information specific to client needs for other covered home management tasks AND exceptions requiring additional time over identified time guidance:

39. Patient's perception of what he/she thinks their needs are:

40. Please check if any of the following apply to this patient:
- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance **and** requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time. ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night

41. Has the patient executed an advance directive (living will or durable power of attorney)? ☐No ☐Yes If yes, specify location of original doc.: _____

42. Is there a DNR order? ☐No ☐Yes If yes, was DNR order discussed with pt.? ☐Yes ☐No
Has a copy of the DNR been obtained? ☐Yes ☐No If no, has the MD been contacted to obtain copy? ☐Yes ☐No

43. SAFETY ASSESSMENT: Is the patient's home adequate or suitable to carry out the Plan of Care according to your agency's policies? ☐Yes ☐No
Water: _____ Telephone: _____ Heating: _____ Cooling: _____
Electric Capability Sufficient? ☐Yes ☐No Is there a smoke alarm in the home? ☐Yes ☐No Is there a fire extinguisher in the home? ☐Yes ☐No
If O_2 is in use, have safety precautions been included on Plan of Care? ☐Yes ☐No ☐N/A Are there safety devices located in the bathroom? ☐Yes ☐No
Are patient emergency numbers in clear view? ☐Yes ☐No Is the patient confined to bed or chair? ☐Yes ☐No
Has patient been instructed on the use of Durable Medical Equipment? ☐Yes ☐No List the DME company used : _____
Specify what DME is already available: _____
Specify what DME has been ordered: _____

44. Are there sources (family, friends, programs, or agencies) available to meet the above needs at the time that services have been requested? ☐Yes ☐No

NURSE ASSESSOR CERTIFICATION

I certify that I, and no one else, have completed the above in-home assessment of the patient's condition. Falsification: an individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the NC Board of Nursing for investigation.

☐ Based on the assessment, I have determined that the patient needs Personal Care Services due to the patient's medical condition. I have developed the plan of care to meet those needs.

☐ I have determined that the patient does not meet the criteria for personal care services.

PRINT RN NAME _____ RN SIGNATURE _____ Date Signed: _____ Time in /out of home

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PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:

PLAN OF CARE

45. If the assessment indicates that the patient has medically-related personal care needs requiring Personal Care Services, show the plan for providing care beside the day(s) services are needed. Please write in the category # of the assigned task(s) that is designated on the assessment. The key below lists the category numbers. Be sure to write in the time (in 15 minute increments or in hours) required for each day.

Category #	Category Name	Category #	Category Name
19	Ambulation	27	Dressing
20	Non-ambulatory/Transfer	28	Bladder
21	Nutrition	29	Bowel
22, 23	Respiration	30	Self-monitoring
23	Endurance	30	Medication Assistance
24	Skin	31	Pain
25	Bathing	32	Cognitive Skills for Daily Decision-making
26	Personal hygiene	33	Behavior

Day of the Week	Task(s) To Be Accomplished Specify the category # and the amount of time required for each task (i.e. # 19: 15 minutes)	Total Time per Day *(in 15 min increments or in hours)*
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

46. **Goals/Objectives:** The need for PCS is expected to ☐change OR ☐end on ____/____/____. If no change is expected, state why:

_____

47. Has a **verbal order** been obtained to **assess the patient** and determine eligibility for PCS per DMA Guidelines? ☐Yes Date:_____

48. Specify the date that a verbal order was obtained to **start PCS**:_____ Who conveyed/obtained this verbal order?_____

PHYSICIAN CERTIFICATION

I certify that I am the patient's primary physician and the patient is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the Personal Care Services in the above plan of care. Falsification: an individual who certifies a false statement in this plan may be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Medicine.

ATTENDING PHYSICIAN'S SIGNATURE _____ DATE_____

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